



HEALTHCARE PROVIDER SERVICES: INPATIENT AND SURGERY

BRIEF COVERAGE STATEMENT

This Benefit Coverage Standard describes the services physicians and other health care professionals may provide to Colorado Medicaid clients who are in need of surgery, or who are receiving services in an inpatient setting. It includes:

- Surgery services (inpatient and outpatient)
- Inpatient hospital services
- Intensive care services

SERVICES ADDRESSED IN OTHER POLICIES

Many related services, as grouped below, may be described, in greater detail, within the following Benefit Coverage Standards.

SCREENING AND DIAGNOSTIC TESTING

- Angiography
- Computed Tomography Scans
- Echocardiogram
- Laboratory
- Magnetic Resonance Imaging
- Positron Emission Tomography
- Radiology
- Ultrasound
- Women's Health

PHYSICIAN AND NON-PHYSICIAN SERVICES

- Maternity Services
- Mental Health FFS
- Speech Language and Hearing Services
- Women's Health Services
- Immunizations
- Occupational Therapy and Physical Therapy
- Office Administered Injectable Drugs
- Podiatry



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- Telemedicine
- Office Visits

SURGICAL SERVICES

- Anesthesia
- Bariatric Surgery
- Disorders of Sex Development and Intersex Surgical Remediation
- Transplants
- Women's Health

CLINIC SERVICES

- School-Based Health Services
- Public Health Clinics
- Dialysis Centers
- Ambulatory Surgery Centers

ELIGIBLE PROVIDERS

The following providers are eligible to provide inpatient health care services for Colorado Medicaid, within the scope of their practice:

- Physicians
- Osteopaths
- Physician Assistants
- Advanced Practice Nurses
- Dentists
- Registered Nurses
- Other Non-Physician Practitioners as specified below

Eligible providers must be enrolled with Colorado Medicaid in order to bill for services.

NON-PHYSICIAN PROVIDERS

Advanced Practice Nurses may order and provide covered goods and services in accordance with the scope of practice as described in the Colorado Revised Statutes without a physician order.

Registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, licensed/certified respiratory therapists, and licensed physician assistants may provide services ordered by a physician. Services shall be rendered in accordance with the scope of practice for the non-physician practitioner described in the Colorado Revised Statutes. If no state law is applicable to the non-physician practitioner, the scope of practice shall meet the requirements of a national certification body. Non-physician practitioner supervision shall meet the specific requirements of the state laws governing each clinical specialty. If no state



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law is applicable to the non-physician practitioner, the supervision shall meet the requirements of a national certification body.

All other non-physician practitioners may only provide services under the Direct Supervision of a provider who is permitted to supervise care of the non-physician practitioner according to the Colorado Revised Statutes. Direct Supervision means the supervising provider shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service. Services required to be delivered under Direct Supervision of a provider permitted to supervise care in the Colorado Revised Statutes must be billed to Medicaid by the supervising provider.

Note: See the Colorado Code of Regulations 10 C.C.R. 2505-10, Section 8.200 et seq. for rules covering non-physician practitioners.

OUT-OF-STATE PROVIDERS

Out-of-state providers enrolled as providers with Colorado Medicaid may provide services in these situations:

- For residents of Colorado border localities where the use of medical resources in the adjacent state is common (A listing of recognized Colorado border towns is in the Appendix F in the provider services billing manual section).
- For Colorado Medicaid clients who live in other states under special circumstances, such as foster care.
- For emergency services provided to Colorado Medicaid clients who are traveling or visiting outside Colorado (documentation of the emergency must be submitted with the claim).
- For services that are unavailable in Colorado (services must be prior authorized).

ELIGIBLE CLIENTS

All Colorado Medicaid-enrolled clients are eligible to receive services when medically necessary, as documented in the Covered Services sections of this standard.

SPECIAL PROVISION: EXCEPTION TO POLICY LIMITATIONS FOR CLIENTS AGED 20 AND YOUNGER

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid program that requires the state Medicaid agency to cover services, products, or procedures for Medicaid clients ages 20 and younger if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition (health problem) identified through a screening examination (includes any evaluation by a physician or other licensed clinician). EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.



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EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is

- Unsafe, ineffective, or experimental/investigational.
- Not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

COVERED SERVICES AND LIMITATIONS

GENERAL LIMITATIONS ON INPATIENT AND SURGERY BENEFITS

Covered services will be reimbursed when medically necessary as defined in the Colorado Code of Regulations 10 C.C.R. 2505-10 Section 8.076.1.8.

Professional services reimbursed to the provider must conform to the ordering and rendering rules governing physician services in the Colorado Medicaid Program, see the Colorado Code of Regulations 10 C.C.R. 2505-10, Section 8.200 et seq.

In general, a **non-covered** service is any that:

- Is not reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability;
- Has not been ordered in writing, and signed (when orders are required) by a physician or other provider acting within their scope of practice;
- Is primarily cosmetic;
- Is provided without the full knowledge and consent of the recipient or the recipient's legal guardian.

Note: This provision may not apply in an emergency;

- Is not provided within the United States.

Note: This is inclusive of the 50 states of the Union, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa;

- Is experimental or investigational as defined in the Colorado Code of Regulations, 10 C.C.R. 2505-10 Section 8.011.11.



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PRIOR AUTHORIZATIONS

Some services require prior authorization. In these cases, it is the requesting provider's responsibility to supply adequate and complete information in a prior authorization request. A list of services that require prior-authorization may be found in the Fee Schedule

The following services must be prior authorized:

- Services that are unavailable in Colorado
- Services that must be performed out-of-state because the individual's health would be endangered if they were required to return to Colorado for medical care

Note: No prior authorization is required in the case of an emergency. This includes emergency services provided out of state.

CONSULTATION:

Consultation in the inpatient setting is not a covered service.

SUBPART 1: INPATIENT HOSPITAL PROVIDER EVALUATION AND MANAGEMENT SERVICES

BRIEF COVERAGE STATEMENT

Evaluation and management services are face-to-face provider and client encounters for the purpose of assessing health status and providing treatment.

ELIGIBLE PLACES OF SERVICE

- Hospital

ELIGIBLE CLIENTS

- All Colorado Medicaid enrolled clients

COVERED SERVICES AND LIMITATIONS

- One inpatient hospital claim per client, per day for the same or a related diagnosis.

Note: Multiple visits should be reported using the appropriate procedure code.



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- Professional inpatient services during the global surgery post-operative period, only if they are performed on an emergency basis and are unrelated to the original surgery.
- Emergency care evaluation and management services may be reimbursed to private physicians or hospital-based physicians who are not salaried by a facility when the services are provided in the emergency facility of a hospital.
- One observation service per day, per client, provided on a hospital's premises. These services must be necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.
- Medical team conferences conducted with an interdisciplinary team of health professionals or a representative of community agencies for the purpose of coordinating a client's care. The medical record must document the contents of the conference and the amount of time spent in the conference.

NON-COVERED SERVICES

The following services are not billable as part of evaluation or management:

- Second opinions
- Standby services of less than 30 minutes, or those billed in addition to any other procedure code.

SUBPART 2: NEONATAL AND PEDIATRIC CRITICAL AND INTENSIVE CARE PROVIDER SERVICES

BRIEF COVERAGE STATEMENT

Neonatal and pediatric critical care services are services provided by qualified practitioners directing the inpatient care of critically ill newborns and children. Neonatal and pediatric critical care services involve high complexity decision making to manage, monitor and treat a critically ill patient.

Neonatal and pediatric intensive care services are services provided by physicians directing the continuing inpatient intensive care of the low birth weight (LBW) or very low birth weight (VLBW) infant who is no longer critically ill but continues to require intensive observation and frequent services and interventions only available in the intensive care setting.

ELIGIBLE PLACES OF SERVICE

- Hospital



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ELIGIBLE CLIENTS

- Medicaid clients aged twenty (20) and under who are critically ill or have low or very low birth weight.

COVERED SERVICES

- Up to six units per day for any provider, for critical care.
- Up to three units per day for any provider, for intensive care.

NON-COVERED SERVICES

- Care for newborns, infants, and very young children who require continued hospitalization but who are not critically ill and weigh more than 2500 grams is not covered under this service.
Note: Providers must bill such care using regular inpatient codes.
- Time spent in activities that occur outside of the unit or off of the hospital floor may not be reported as critical care unless the physician is immediately available to the client.
- Time spent performing activities that do not directly contribute to the treatment of the client may not be reported as critical care, even if they are performed in the critical care unit.
- Time spent performing separately reportable procedures or services may not be included in the time reported as critical care time.

SUBPART 3: CRITICAL CARE PROVIDER SERVICES

BRIEF COVERAGE STATEMENT

Critical care should be provided only to those clients with life-threatening injuries and illnesses. It involves close, constant attention by a team of specially-trained health professionals and usually takes place in an intensive care unit (ICU) or trauma center. Problems that might need critical care treatment include - but are not limited to - complications from surgery, accidents, infections and severe breathing problems.

ELIGIBLE PLACES OF SERVICE

- Hospital

ELIGIBLE CLIENTS

- Colorado Medicaid enrolled clients in need of critical or intensive care services.



COVERED SERVICES

- Up to six units per day for any provider.

NON-COVERED SERVICES

- Time spent in activities that occur outside of the unit or off of the floor may not be reported as critical care unless the qualified provider is immediately available to the client.
- Time spent performing activities that do not directly contribute to the treatment of the client may not be reported as critical care, even if they are performed in the critical care unit.
- Time spent performing separately reportable procedures or services may not be included in the time reported as critical care time.

SUBPART 4: SURGICAL SERVICES

BRIEF COVERAGE STATEMENT

Surgical services are manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases. Certain surgeries require prior authorization or have other restrictions. These restrictions are described in detail in other Benefit Coverage Standards, as specified on page 2 of this standard.

This section describes those services that providers may bill as global surgery payments.

ELIGIBLE PLACES OF SERVICE

- Federally Qualified Health Center.
- Hospital
- Ambulatory Surgery Center.
- Rural Health Clinic
- Provider office

ELIGIBLE CLIENTS

- All Colorado Medicaid enrolled clients

COVERED SERVICES

- Preoperative visit the day of surgery.
- Intraoperative Services (common, necessary services provided in the course of a surgical procedure). Examples are local anesthetic, digital block, or topical anesthesia.



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- Services to correct complications following surgery. These services are additional medical or surgical services, that do not require additional trips to the operating room, required of the surgeon during the postoperative period of the surgery due to complications.
- Post surgical pain management by the surgeon.
- Surgical services and supplies, such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints.
- Insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; changes and removal of tracheostomy tubes.
- Postoperative Visits. The postoperative follow-up period is 0-10 days for minor surgery and 90 days for major surgery, depending on the procedure.

NON-COVERED SERVICES

The following services are not billable as part of a surgical procedure:

- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Treatment for postoperative complications that require a return trip to the operating room.
- Critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- Anesthesia services ordered by the surgeon and performed by qualified providers are separately billable and not covered in the global surgery payment.

PROVIDER PREVENTABLE CONDITIONS

Provider Preventable Conditions (PPCs) and Other Provider Preventable Conditions (OPPCs) are Health Care Acquired (HAC) Conditions, not present on hospital admission.

OPPCs are conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Conditions currently identified by CMS include:

- wrong surgical or other invasive procedure performed on a patient;
- surgical or other invasive surgery performed on the wrong body part;
- and surgical or other invasive procedure performed on the wrong patient.

COMPLICATIONS TO NON-COVERED CARE

- Services that are normally performed as part of a non-covered service, as specified in this standard, are not billable, regardless of the reason for the service.
- Treatment of unexpected medical complications resulting from non-covered services (e.g. post-operative bleeding, wound infection, allergic reaction) is a covered service.



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- The Chief Medical Officer of Colorado Medicaid will determine, on a case-by-case basis, when services relating to complications resulting from non-covered care are to be covered.

REFERENCES

10 CCR 2505-10 § 8.660 Laboratory and X-ray

10 CCR 2505-10 § 8.282 Services/Benefits

10 CCR 2505-10 § 8.300.12 Utilization Management

10 CCR 2505-10 § 8.217 Prior Authorization Review

10 CCR 2505-10 § 8.200.8 Reimbursement

Current Procedural Terminology-CPT 2010 Standard Edition. American Medical Association.
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